

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046049	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/15/2014
NAME OF PROVIDER OR SUPPLIER BRIGHTON GARDENS OF PRAIRIE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208		
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S 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #76829.	S 000		
S3081 SS=D	26-41-201 (c) Functional Capacity Screen Reassessment (c) Designated facility staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: K.A.R.26-41-201(c)(2) The facility census totaled 25 residents with 3 residents sampled. Based on observation, record review, and interview, the facility failed to conduct a Functional Capacity Screening after a change in condition for for 2 of 3 residents sampled (#1, #2). Findings included: - Resident #1's Functional Capacity Screen (FCS) dated 8/11/13 documented the resident required physical assistance with the activities of daily living of bathing, dressing, toileting, transfers, walking/mobility, and eating. The FCS documented the resident was occasionally incontinent of bladder. The FCS documented the resident used the mobility devices of cane,	S3081		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S3081	<p>Continued From page 1</p> <p>walker, or crutch.</p> <p>On 7/11/14 at 8:00 A.M. direct care staff O was getting the resident up for the day. The resident was incontinent of urine, staff provided peri care, applied a new brief, and pulled the resident's pants up. Direct care staff P sat the resident on the side of the bed and direct care staff O applied his/her socks and shoes. Direct care staff O and P lifted the resident into the wheelchair. Direct care staff O pushed the resident in his/her wheelchair to the dining room and asked direct care staff Q to help reposition the resident in the wheelchair to help the resident sit up straighter.</p> <p>On 7/11/14 at 12:25 P.M. direct care staff O fed the resident 100 percent (%) of a bowl of vegetable soup, rice and peas. The resident was unable to feed him/herself.</p> <p>On 7/11/14 at 8:00 A.M. direct care staff O revealed the resident was total care. The resident could not do anything for him/herself.</p> <p>On 7/14/14 at 10:30 A.M. administrative nursing staff D revealed the Functional Capacity Screen was not updated per the company's policy which would be every 6 months or with any significant change in condition.</p> <p>The facility failed to provide a policy related to the Functional Capacity Screen.</p> <p>The facility failed to complete a Functional Capacity Screening after a change in the resident's condition.</p> <p>- Resident #2's Functional Capacity Screen (FCS) dated 8/11/13 documented the resident</p>	S3081			

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S3081	<p>Continued From page 2</p> <p>required physical assistance with the activities of daily living of bathing, dressing, toileting, walking/mobility, and eating.</p> <p>On 7/11/14 at 2:30 P.M. the resident slept in the activity room in his/her wheelchair. Direct care staff Q wheeled the resident to his/her room. Direct care staff P and direct care staff Q manually lifted the resident into his/her bed. Direct care staff Q checked to see if the resident was incontinent and repositioned the resident on his/her right side.</p> <p>On 7/11/14 at 2:30 P.M. direct care staff P revealed the resident fed him/herself and would not let anyone help him/her. The resident was total care with activities of daily living.</p> <p>On 7/14/14 at 10:30 A.M. administrative nursing staff D revealed the Functional Capacity Screen was not updated per the company's policy which would be every 6 months or with any significant change in condition.</p> <p>The facility failed to provide a policy related to the Functional Capacity Screen.</p> <p>The facility failed to conduct a Functional Capacity Screening after a change in the resident's condition.</p>	S3081			
S3085 SS=D	<p>26-41-202 (a) Negotiated Service Agreement</p> <p>(a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident 's functional capacity screening, service needs, and preferences, in collaboration</p>	S3085			

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S3085	<p>Continued From page 3</p> <p>with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information:</p> <p>(1) A description of the services the resident will receive;</p> <p>(2) identification of the provider of each service; and</p> <p>(3) identification of each party responsible for payment if outside resources provide a service.</p> <p>This REQUIREMENT is not met as evidenced by: K.A.R.26-41-202(a)(1)(2)</p> <p>The facility census totaled 25 residents with 3 residents sampled. Based on observation, record review, and interview, the facility failed to provide Negotiated Service Agreements to accurately reflect the residents' needs for 2 of 2 residents sampled (#1, #2).</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Resident #1's Negotiated Service Agreement updated 6/24/14 documented the resident with a pressure ulcer on his/her coccyx which developed related to immobility. The interventions included: to monitor dressings to ensure the dressing remained intact and adhered, report loose/soiled dressings to license nurse, and home health services twice a week. <p>The medical record revealed on 6/23/14 the home health services were discontinued.</p>	S3085		

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S3085	<p>Continued From page 4</p> <p>On 7/14/14 at 10:30 A.M. administrative nursing staff D revealed the Negotiated Service Agreement was not accurate.</p> <p>The facility failed to provide a policy related to the Negotiated Service Agreement.</p> <p>The facility failed to provide a Negotiated Agreement to reflect the resident's current needs.</p> <p>- Resident #2's Negotiated Service Agreement (NSA) updated 4/13/14 documented the resident with a pressure ulcer in the sacral area which developed related to immobility. The interventions included: to monitor dressings to ensure the dressing remained intact and adhered and report loose/soiled dressings to the license nurse.</p> <p>The NSA documented the resident received end of life care with the intervention to collaborate with the hospice team members.</p> <p>On 7/11/14 at 10:30 A.M. hospice nurse KK provided wound care to the resident and revealed he/she was working for a different agency than documented on the resident's NSA.</p> <p>On 7/14/14 at 10:30 A.M. administrative nursing staff D revealed the Negotiated Service Agreement was not accurate.</p> <p>The facility failed to provide a policy related to the Negotiated Service Agreement.</p> <p>The facility failed to provide a Negotiated Agreement that identified the hospice provider.</p>	S3085		

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S3171	Continued From page 5	S3171			
S3171 SS=D	<p>26-41-204 (i) Health Care Services Standards of Practice</p> <p>(i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice.</p> <p>This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-204(i)</p> <p>The facility census totaled 25 residents with 3 residents sampled. Based on observation, record review, and interview, the facility failed to provide the necessary services to promote the healing of pressure ulcers for 1 of 3 residents sampled with pressure ulcers (#1).</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Resident #1's Negotiated Service Agreement updated 6/24/14 documented the resident with a pressure ulcer on his/her coccyx which developed related to immobility. The interventions included: to monitor dressings to ensure the dressing remained intact and adhered, report loose/soiled dressings to license nurse, and home health services twice a week. <p>On 7/11/14 at 10:00 A.M. licensed nursing staff H applied gloves, repositioned the resident on his/her right side and removed 2 dressings covering the wounds. The dressing on the coccyx had feces at the base of the dressing. Licensed nurse H removed his/her gloves and left the room to get new dressings to cover the pressure ulcers. Licensed nurse H returned to the room with the dressings and placed the dressings on the resident's pillow. Licensed nursing staff H applied a new pair of gloves without washing his/her</p>	S3171			

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S3171	<p>Continued From page 6</p> <p>hands. Licensed nursing staff H provided wound care to both wounds then applied the new dressing to both wounds without removing his/her gloves and washing his/her hands. Staff repositioned the resident and licensed nurse H removed his/her gloves, gathered the trash, and took the trash to the utility room. Licensed nurse H stopped and cleaned his/her hands with alcohol gel from a wall mount dispenser in the hall way.</p> <p>On 7/11/14 at 2:30 P.M. administrative nursing staff D revealed the staff should wash their hands when doing wound care, before removing the dressing, after removing the dirty dressing, and after the treatment was done.</p> <p>The 10/29/13 facility policy "Skin Integrity Management" documented the purpose of this policy was to inform team members of the process to promote and maintain healthy skin integrity.</p> <p>The facility failed to provide wound treatment using appropriate infection control techniques.</p>	S3171		